Injuries in Missouri

Focus on Assault Injuries

Focus on Assaults

Definitions:

Struck By/Against – Assault injuries categorized at struck by/against include: unarmed fights or brawls; beating another person with hands, fists, or feet; and striking another person with a blunt or thrown object.

Cut/Pierce – Assault by cutting or piercing instruments includes: cutting, puncturing, or stabbing any part of the body.

Firearms – Assault injuries by firearms include: handguns, shotguns, hunting rifles, military firearms, other specified firearms and unspecified firearms.

Spouse/Partner Abuse – Spouse/Partner Abuse is the result of battering and other maltreatment by a spouse or partner. Spouse/Partner Abuse is often referred to as intimate partner violence.

Sexual Abuse – Sexual Abuse is the result of nonconsensual sexual contact obtained by force, threat, or fraud by a caretaker.

Physical/Other Abuse – Physical abuse is the result of battering by a caretaker, excluding spouse/partner abuse, sexual abuse, struck by/against, cut/pierce, firearms, and rape.

Rape – Rape is defined as nonconsensual sex obtained by force or threat by someone other than a spouse/partner or caretaker.

The Problem:

During 1999, assaults accounted for 24,271 injuries that required a visit to an emergency room or hospitalization. Persons with assault injuries were admitted to an emergency room or hospitalized every 20 minutes. Victims of: spouse or partner abuse were admitted every 8 hours, physical and other abuse every 8 hours, or sexual abuse every 18 ½ hours.

The rate of assault-related injuries was highest among 15 to 24 year old males (1,358.9 per 100,000) in 1999. Females of the same age group had the third highest rate (778.2) in 1999 following males ages 25-44 (830.3). Assault-related injuries were more prevalent among blacks than whites. The rate of assault-related injuries for blacks was 1,284.1 per 100,000 compared to whites, 316.8 per 100,000.

Struck by or against was the leading mechanism that accounted for 57% (13,892) of all reported assault-related injuries in 1999. Cut or pierced was second with 1,619 injuries followed by spouse or partner abuse (914), physical and other abuse (752), and firearms (618).

Women are much more likely than men to be assaulted by an intimate partner. Compared to 8% of men, 25% of women were raped and/or assaulted by a current or former spouse/partner/date in their life. Most intimate partner violence committed against adults is done by males. Ninty-three percent (93%) of women and 86% of men who were raped or physically assaulted since age 18 were assaulted by men. Seventy-six (76%) percent of

Focus on Assaults

women who were raped/assaulted since the age of 18 were assaulted by a current or former husband/partner/date. Women are more likely than men to be murdered in the context of intimate partner violence. In 1998, 32% of all female homicide victims were murdered by an intimate partner. In contrast, 4% of male murder victims were killed by an intimate partner.

Women who are sexually assaulted as children and adolescents are at greater risk of being sexually assaulted as adults. Fifty-four percent (54%) of female rape victims were under 18 years old when they experienced their first rape. An increased frequency of violence toward a spouse is associated with an increased risk of the violent spouse also being abusive to the child.

The Youth Risk Behavior Survey (YRBS) indicates that adolescent behaviors associated with violence have remained relatively flat or have decreased slightly from the 1997 school year to the 2001 school year. The percent of students who carried a weapon within the last 30 days was 21% in 1997 and 1999. The percent of students who carried a gun increased to 9% in 2001 from 8% in 1997 following a slight decrease in 1999 (7%). The percent of students who carried a weapon on school property within the past 30 days declined slightly over the six-year period (1997-10%, 1999-9%, and 2001-8%). This is in contrast to the percent of students who reported being threatened or injured with a weapon on school property during the past 12 months (1997-8% and 2001-9%). The percent of students who did not attend school because they felt unsafe at school or on the way to school increased from 4% in 1997 to 6% in 1999 and 2001.

During 1999, inpatient and outpatient hospital costs associated with injuries resulting from violence totaled approximately $42 million in Missouri; of this total, approximately $2.5 million were paid by Medicaid. This evidence makes it clear that violence is not only a public safety issue, but it is also a significant public health issue.

Evidence-Based Prevention Interventions:

For Individuals/Parents:

- ✓ Report abuse and neglect to authorities to prevent repeated abuse.
- ✓ Discourage bullying, displaying aggression, and other anti-social behaviors in adolescents.
- ✓ Provide close supervision of children and adolescents, provide positive reinforcement of appropriate behaviors, and provide constructive activities as positive alternatives to watching TV, videos, or video games.
- ✓ Acknowledge the importance of mental health to the well-being of families, children, and individuals.
- ✓ Seek counseling as needed to address issues with aggression, self-esteem, alcohol, drug, and school problems.

For Community Leaders and Policy Makers:

- ✓ Encourage and assist schools in developing and enforcing guidelines to:
  - ◆ Establish a social and physical environment that promotes safety and prevents violence.

Focus on Assaults

- Implement health and safety education curricula to aid students in developing the knowledge, attitudes, behaviors, and skills to adopt and maintain safe lifestyles.
- Provide health, counseling, and psychological and social services to meet the physical, mental, emotional, and social health needs of children and adolescents.
- Establish procedures to respond to crises that affect the school community.
- Provide staff development services for all school personnel to educate students and build the students' knowledge, skills, and confidence to prevent violence and other injuries.

✓ Encourage and establish protocols for all health providers to counsel all women and girls of all ages about domestic violence, abuse, neglect, and sexual assault.

✓ Encourage and establish protocols for screening all female patients for domestic violence.

✓ Encourage and establish educational programs to teach conflict-resolution skills for schools, the faith community, health-care providers, and other community agencies and institutions.

✓ Encourage and establish community education about the social, emotional, and economic impacts of violence on individuals and the community.

✓ Encourage strong enforcement of laws related to drug and alcohol consumption and consider enacting stricter laws directed toward adolescents and young adults.

✓ Improve linkages between law enforcement agencies and social service agencies in response to violence.

✓ Implement multi-dimensional programs to address negotiation skills, critical thinking and decision making; identifying, managing, and coping with feelings; anticipating the consequences of aggressive verbal and nonverbal behavior; finding nonviolent alternatives to conflict and moral reasoning. Programs of this nature should be targeted to families of young children. One example of this type of program is FAST (Families and Schools Together).